

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. **42156**Registrar's No. **10613**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION 4055a Finney Avenue			4. STREET ADDRESS (If rural, give location) 4055a Finney Avenue		
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) _____ c. (Last) Day			4. DATE OF DEATH (Month) (Day) (Year) 12/8/50		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY _____		8. DATE OF BIRTH 6/30/1909	
				9. AGE (In years last birthday) 41 If under 1 year: Months _____ Days _____ If under 12 hrs: Hours _____ Mins. _____	
				11. BIRTHPLACE (State or foreign country) Jasper Co., Mississippi	
				12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Geo. Ratcliff		13b. MOTHER'S MAIDEN NAME Indiana Smith		14. NAME OF HUSBAND OR WIFE Mack Day	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-22-1801		17. INFORMANT'S SIGNATURE OR NAME Ella Keels ADDRESS 725 Carpenter Pl.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intra cerebral hemorrhage ANTECEDENT CAUSES Contrib. Hypertension DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 321X	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:35 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE E. J. Gates (Degree or title)		23b. ADDRESS 1300 Clark Avenue		23c. DATE SIGNED 12/14/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/14/50		24c. NAME OF CEMETERY OR CREMATORY Washington Pk. Cem.	
				24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. DEC 12 1950		REGISTRAR'S SIGNATURE J. B. Jester		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates ADDRESS 4107 Finney Avenue	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.....

Licensed Embalmer No. 4476

P. O. Address: 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.